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Convalescent care in Louisville, Kentucky.

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CONVALESCENT CARE IN LOUISVILLE, KENTUCKY

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INTRODUCTION

INTRODUCTION

This study is undertaken to survey and evaluate the adequacy of convalescent facilities available for indigent persons who have been under the care of the surgical service at the Louisville General Hospital. The adequacy of convalescent care will be measured first, in relation to its scope, second, in relation to its help to the patients, and third, in its interaction with other community agencies. The study is prompted by the recognition of the fact that convalescence is a sadly neglected field of medical care.

Convalescence will be defined for the purposes of this study as the more or less gradual return towards normal after a period of physical or mental disability. The approach to this aspect of need for medical care should be made with the realization that no medical history is complete until the story of the convalescent period is complete. A patient may have recovered from illness and still be unprepared to assume routine duties. It is the management of this period of medical care that has not been satisfactorily supervised in the past.

In considering adequate convalescent care, we must think in terms of the individual and of his nutritional, psychosomatic, and economic condition. It should be considered as a continuing service in which the physician, the hospital and social service, all have a share.

"Convalescence has a hopeful connotation, which should not be denied to those whose recovery cannot be complete in the sense that they will become entirely free from disease, but who will recover the ability to carry on their normal activities. The present day conception of health is not merely freedom from disease or bodily perfection but the harmonious functioning of the whole complex human organism..."[1]

Acute diseases, that is those with a self limited course, and many surgical operations call for a few weeks of relatively simple convalescent care, if there are no complicating adverse mental or social factors. If such factors are present, however, a more elaborate technique is required. Surgical operations in which the body functions are deeply disturbed or in which the patient may have been in poor physical condition, may require many weeks or months of individual treatment during convalescence.

It has been observed that the reaction of an individual to a short illness may be quite unlike his reaction to a longer one. At the onset of an acute illness, for example, some persons will go to bed at once and will enjoy the care afforded them, while others will go through a period of conflict trying to decide whether or not to give in to

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[1]Mary C. Jarrett, "Convalescent Service in Relation To A Community Health Program" (Unpublished confidential Report of the Welfare Council of New York City Research Bureau, New York, August, 1934), p. 4.

their illness. They may, for a variety of reasons, try to deny it and spur themselves on to greater activity. It may be that for them illness is a symbol of weakness. Family attitudes, as well as those of the individual will influence his attitudes toward his illness and toward his recovery.[1]

In reviewing the trends of medical development during the last hundred years, one is impressed by the fact that more energy, time, and money has been devoted to the treatment of illness than to prevention or to recovery. In the last quarter of a century, there has been a growth in preventive medicine. Prevention may be thought of as the frontal attack on disease and convalescence as the rear attack. Adequate convalescent care lessens disease and also contributes to prevention. At present, it is the weak segment of the circle of organized effort for the control of disease. Doctors and public health officials who have been aware of this weakness in our medical program attribute its neglect to a lack of financial support.[2]

An exception to this generalization regarding programs for after care of the acutely ill person is found in the immediate neighborhood of New York City. There the ratio of beds for convalescent patients to beds for acute

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[1]Gordon Eckka, "Treatment of Problems of Dependency Related to Illness," The Family, October, 1942, p. 210.

[2]Ibid.

hospital patients is said to be up to the estimated minimum needed. According to the estimates of Doctor John Bryant, this minimum is thought to be ten per cent of all hospital patients plus a small percentage for dispensary patients. This percentage varies according to the individual needs of the community and existing conditions in that community. Fifty per cent of all convalescence facilities in the United States are concentrated in the vicinity of New York City. It is evident, then, that the rest of the country has inadequate resources.[1]

The absence of convalescent homes throughout the country has necessitated the use of ingenuity on the part of medical social workers in devising more or less satisfactory substitutes for the care of patients. This process might be good case work, "but it has failed to focus the attention of the community, and those persons concerned with social problems, on creating the needed resources, thus leaving the majority of patients recovering from serious illness without adequate care."[2]

The study of available resources for convalescent care in Louisville grew out of the need for some provision

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[1]E. H. L. Corwin, "Convalescent Care," Social Work Year Book, (New York: Russell Sage Foundation, 1930), p. 106.

[2]Elizabeth Green Gardiner, Convalescent Care in Great Britain,(Chicago: University of Chicago Press, 1935) p. 2.

for the convalescence of the patients who had experienced an acute illness on the surgical wards of the Louisville General Hospital, and who, for various reasons could not be cared for adequately in their own homes, or who would need some type of supervised service to aid recovery in their homes. The homes of a majority of the patients in the public institutions have always been overcrowded, and, therefore, people have sought admission to the hospital during periods of illness. This created great pressure for beds in hospitals which automatically led to early discharge, and return of the patients to unsuitable homes, unless some other provision was made on an individual basis for cases of most pressing need.[1]

In an effort to demonstrate the needs of more adequate provisions for convalescence of persons leaving the surgical wards at the Louisville General Hospital, a study of seventy-five surgical cases has been undertaken. Although the survey has been restricted to surgical patients, it is not intended to imply that the need for convalescence is restricted to this group alone. The basic psychological and physiological needs in convalescence are extended into all forms of mental and physical health.

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[1] Ibid., p. 27.

CHAPTER I

THE DEVELOPMENT OF CONVALESCENT CARE

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Although suggestions for expediting convalescence may be found in the writings of Hippocrates and Gales and Celsus, it was only comparatively recently that the first community efforts were made to provide for patients leaving hospitals after severe illness, the opportunity for the peace of mind, moderate exercise, proper nutriment, and recreation, which the ancients had recognized as requisite for rapid recovery.

The French especially have written on the need of facilities for convalescent care, but the English have provided it to the extent hitherto unsurpassed by any nation. The first institutions of this character were established in England. Only nine convalescent homes had been founded prior to 1850, which is the turning point in the history of institutional convalescence, as forty new institutions were founded in Great Britain between 1850 and 1870.[1] Simultaneously, two convalescent homes of over four hundred beds

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[1] Ibid., p. 30.

each, the largest institutions of the kind on the continent of Europe, that of Vincennes for men, and Visinet for women, were opened respectively in 1857 and 1859 by Napoleon III and Empress Eugenie in the suburbs of Paris.

The influence of Florence Nightingale was no doubt responsible for stimulation of the growth of convalescent homes in England. It may not be amiss to quote a few sentences on the subject from her "Notes on Hospitals."[1]

> It is a rule without any exception, that no patient ought to ever stay a day lonter in a hospital than is absolutely essential for medical or surgical treatment. What, then, is to become of those that are not yet ready for workaday life? Every hospital should have its convalescent branch, and every county its convalescent home.
>
> The first necessity of a convalescent hospital is that it should not be like a hospital at all, and the very best kind of convalescent hospital should be a string of cottages. The reasons for this are, (1) to get rid of the idea of being in a hospital altogether from the minds of the inmates, and to substitute for it that of a home... (2) to secure a more free and bracing atmosphere than can ever be secured in any building containing a larger number of inmates... (3) because cottages may be more slightly built, and therefore are less expensive than large complicated, solid buildings... (4) because in the point of view of moral discipline it is yet more important to separate men from women among convalescents than the sick...
>
> It is also needless to repeat the A B C of all sanitary lessons--that the best building, intended to hold a large number of inmates, can never be made so healthy as a cottage for a small number, if well constructed...

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[1]Florence Nightingale, Notes on Hospitals,(3rd ed.; London: Longmans, 1863).

The appreciation of the need for convalescent homes in the United States came much later than in Europe. The first of the convalescent homes now in existence was St. Phebe's Mission and Convalescent Rest Home, opened in Brooklyn, New York, in 1872. By 1904 there had been established an increased number of facilities for convalescing orthopedic patients, including among them the Robin's Nest, The Blythedale House, and the county branch of the New York Orthopedic Hospital. The period from 1914 to 1925 may be regarded as "the boom" in the development of convalescent homes. This era was ushered in by the opening of the Burke Foundation Convalescent Home in April, 1915, with large accommodations and recreational facilities. During the last ten years only a few homes have been built. Among them should be mentioned the fine complement to St. Luke's Hospital, built on the former Arnold Estate in Greenwich, Connecticut. This is probably the most completely equipped institution for convalescent care.[1]

From this review of the growth of convalescent homes serving the metropolitan population, some deductions can be drawn. Apparently the movement for convalescent care in this country started two decades later than in Great Britain

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[1] E. H. L. Corwin, "Institutions for Convalescent Care", Reprint from the Hospital Survey for New York, Vol. II (1937) pp. 702-706.

or France. It began in a modest way under the auspices of some of the Protestant churches and of certain racial groups, the Hebrew and the German, and it received its major impetus from the realization of the convalescent needs of children and cripples. In so far as specialization in the convalescent field exists, it is still limited largely to patients who have recovered from diseases of childhood, orthopedic conditions and cardiac impairment.

Under the auspices of the Committee on Convalescent Care of the American Conference on Hospital Service, an effort was made in 1930 to collect accurate and complete information upon institutions for convalescent care in the United States. The data secured was published by the Sturgis Fund in 1931. Of the 179 homes listed, 148 were charitable institutions, where care is given free or for a nominal charge; the remaining thirty-one were chiefly institutions in which very moderate rates were charged. The 179 institutions had a combined capacity of 8,747 beds of which 1,237 were available for only part of the year, usually the summer. Twenty-four states had no institutions for convalescent care for people who were able to pay little or nothing. The distributions of the 8,747 beds by states was as follows.

TABLE 1

DISTRIBUTION OF BEDS IN CONVALESCENT HOMES, BY STATES--1930[1]

California	460
Colorado	23
Connecticut	75
District of Columbia	72
Georgia	86
Illinois	279
Indiana	70
Iowa	54
Kentucky	12
Louisiana	30
Maryland	105
Massachusetts	513
Maine	50
Michigan	240
Minnesota	80
Missouri	90
New Jersey	1,010
New York	4,286
Ohio	243
Oregon	18
Pennsylvania	689
Rhode Island	97
Tennessee	30
Virginia	45
Wisconsin	90
Total	8,747

From this table it will be seen that approximately fifty per cent of all the convalescent beds in the country are in New York State, practically all within a short distance of New York City. The courtesy of the convalescent institutions serving the population of New York City and

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[1] Ibid., p. 707.

located outside of the city, is offered to the communities and hospitals in the vicinity, but the services thus provided are inconsiderable.

The Council on Medical Education of the American Medical Association made its twenty-second annual survey of hospital services in the United States during 1942. The report included a section on convalescent and rest homes; however, there is no interpretation given to the meaning of this latter classification. The preceding report, which was published in 1930, excluded all the proprietary institutions, but it is not known whether they were also excluded in the recent survey. The results shown in Table 2 are significant for more than one reason. First, there is a slight increase in the distribution of beds by states. Second, in Table 1 there is a total bed capacity of 8,747. Twelve years later the above mentioned survey shows an increase of 1,046 beds which is comparatively small in relation to the progress made in other fields of medical services. Third, it should be pointed out that in several instances in Table 1 convalescent facilities were indicated in various states, while in the survey of 1942 these states indicated no hospital facilities. The author does not have an explanation for some of the most obvious variations shown. The two surveys cannot, therefore, be accurately compared without interpretation of the schedule and termi-

nology used. The findings are of importance, however, and are quoted for the purpose of presenting a current picture of resources now in existence.

TABLE 2

SURVEY OF CONVALESCENT HOSPITALS AND REST HOMES BY STATES--1942[1]

State	Convalescent Hospitals and Homes	Bed Capacity	Patients Admitted	Average Daily Census
TOTAL	139	9,793	35,929	8,041
Alabama	1	10	200	8
California	14	561	2,821	486
Connecticut	6	517	1,694	405
Washington, D. C.	2	206	137	192
Florida	2	64	184	48
Illinois	2	454	2,351	100
Iowa	1	20	90	16
Kentucky	1	100	26	91
Louisiana	1	33	287	21
Maryland	4	283	391	259
Massachusetts	8	544	811	484
Michigan	5	319	1,174	192
Minnesota	6	429	2,598	323
Missouri	2	102	89	93
New Jersey	12	826	1,682	621
New Mexico	1	25	68	20
New York	19	2,064	9,640	1,773
North Carolina	1	12	313	5
Ohio	8	777	1,649	660
Oregon	1	251	139	10
Pennsylvania	15	841	3,258	763
Rhode Island	2	119	155	110
South Dakota	1	45	151	40
Texas	2	171	137	147
Washington	3	298	1,068	270
Wisconsin	2	117	240	108

[1] "Hospital Service in United States," Journal of American Medical Association, April 27, 1943, p. 1009.

In 1925, the New York Academy of Medicine held a conference on convalescent care. Following it, many studies were conducted in various communities on the importance of convalescences as a part of the whole medical problem, and recommendations were drawn up as a result of the findings. Even with these studies and with the great and almost incredible advances in medical science we are still pioneering in the field of convalescence. In February, 1930, at a meeting devoted solely to Convalescent Care, Dr. Harry E. Mock[1] referred to the need for the medical profession to offer some solution to the problems of the future care of the prolonged disability case after his discharge from the hospital.[2]

Ten years later, in 1940, at a similar meeting, the medical profession found itself still pioneering in the field of convalescence. It is true in certain centers great advances have been made, but the country as a whole is still an unplowed field of endeavor. Excellent hospital facilities and medical and surgical care have been offered in ninety per cent of our communities, but provisions for the complete recovery of these cases after their discharge from

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[1]Henry E. Mock, M.D. "Convalescent Care, the Missing Link in the Cure of Many Patients," Bulletin of the American College of Surgeons, I (January, 1941), 36.

[2]Ibid., p. 37.

the acute hospital are almost non-existent.[1] Surgeons have been absorbed in perfecting pre-operative and post-operative care; hospital administrators have been interested in illness in relation to dollars and cents to keep modern medicine within reach of the masses who are clamoring for it; research workers have sought better controlled and more tangible fields for their endeavors; and social workers have recognized the futility of meeting the special demands for the convalescence of a few when large numbers of the population lack the bare necessities of life.[2]

It is true that in a general hospital there are so many pressing medical problems involving a large number of patients that little time is left, after attending to what appears to be the most urgent needs, for what some regard as the secondary factors of after-care. By this is meant the restoration of the patient to health together with an inquiry into whether the environmental conditions to which the patient returns are conducive to regaining and maintaining health.[3]

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[1] Ibid.

[2] Donald B. Wells, M.D., "Institutional Convalescent Care of the Surgical Patient," Bulletin of the American College of Surgeons, XXVI (April, 1940), 42.

[3] Ogden Woodruff, M.D., "Present Day Concept of Convalescent Care," Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, p. 226.

The knowledge that in a vast majority of cases these environmental factors are seemingly hopeless of correction, and the lack of sufficient personnel in the social service departments to make more than routine inquiries, brings about an attitude of defeatism in doing much for the patient after discharge from the hospital.

Yet the fact remains that the disease, rather than the patient, is still too often the primary interest of many physicians. No worthwhile results in convalescent care will be secured until there is general acceptance as a fundamental principle of the idea that in convalescent care attention must be focused on the patient as a person, who has been ill and is recovering strength, and who has particular and individual problems to be considered in his course of recovery.[1] Even in instances where convalescent care has been arranged, we often fail to do our best for patients in that we look upon this period as one which presents merely an opportunity to rest before returning to home and to work, and in which rest and diet are carried out in a purely routine manner.[2]

We cannot overlook, on the other hand, the relatively recent intelligent interest of some physicians and

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[1] Ibid., pp. 226-227.

[2] Ibid., p. 227.

surgeons in this field. The surgeon has been stimulated by fundamental changes in the practice of surgery. In the past the majority of surgeons considered convalescent care as a means to free hospital beds for acutely ill patients. When, however, surgeons began to realize that further reduction in morbidity and mortality could be accomplished only by a more carefully planned period of pre-operative treatment and by exacting post-operative care, interest in the patient as an entity increased.

It is a matter of great concern to the surgeon who believes that surgery is an art and not a craft, that the results of his work should permanently benefit his patient. To discharge a patient after a serious surgical operation is only a small satisfaction. To see the patient six months or a year later in the follow-up clinic restored to health is the real reward.[1]

Thus, the development of the out-patient clinic has brought a clearer realization of the fact that many patients are discharged from the surgical wards who might benefit by a regulated period of transitional care, if they expect to be restored fully and rapidly to health and economic stability.[2]

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[1] I. S. Ravdin, M. C., "Institutional Convalescent Care for Surgical Patients," Convalescent Care, Proceedings of Conference, p. 79.

[2] Ibid., p. 73.

There comes a time in the recovery from many operations, when active surgical and nursing care are no longer needed, but when it is still not possible to consider that the surgical episode has come to an end. "The aftermath of a period of hospitilization is too often accompanied by moods of depression or of exaggerated self-importance. These are best combatted by a change of environment, and an application of recreational therapy, involving intercourse with others who are similarily in need of reparation and harmonizing guidance and stimulation..."[1]

The patient, who only a few days previously, has had a thyroidectomy for hyperthyroidism may at the time of discharge have a normal basal metabolic rate and a normal pulse rate. He has had, however, a long period of malnutrition and has been left with a hyperirritable nervous system, a heart taxed by overwork, and perhaps muscular and vascular changes. Can those hyperthyroid patients, who frequently have required or should have had the assistance of a trained social worker in working out their social and economic problems prior to hospitalization and operation, return to the environment from which they came? The medical profession feels definitely that they cannot. Even those patients who do not belong to what we call the "charity

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[1]E. H. L. Corwin, "Convalescent Homes," Nelson's Loose Leaf Library, (New York: T. Nelson and Sons, 1940), Vol. VII.

group", have done better when for a period of from two to six weeks following discharge from the hospital, the have been provided with special care, removed from the pressure of everyday life. The profound psychosomatic readjustment which these patients must make can rarely be made in the same environment in which they lived during the progress of this disorder.[1]

The patient recovering from a radical resection of the breast for cancer, may not require a special diet, but she requires a considerable period for the psychological adjustment which is necessary following what she considers a mutilating operation. Where can this adjustment be made more promptly than among a group recovering from a variety of illnesses.

Operations for rectocele and cystocele are among the commonest done in every gynecological service. These lesions are in reality a form of herniation. When the general surgeon repairs a hernia, he advises a period of from two to four months during which no heavy lifting must be performed, and yet every day women are being discharged to go to home where from the start they must do work which interferes with the successful recovery from the operation.

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[1]Ravdin, op. cit., p. 74.

The patient with a fracture, especially of the lower extremity, requires considerable care even after bone union has taken place. Massage, baking, diathermy, and planned exercises are important in the post-surgical care of patients who have had a fracture of one or more of the major long bones. They may no longer require hospital care but if they are to be restored to their usual routine of life, they require institutional care.[1] It is not practical that they be transported to the hospital daily for treatment, as it would often be necessary if the patient were returned to his home.

Another group who could profit from convalescent care are those neuro-surgical patients who are learning again nerve and muscular coordination. Often these patients are rejected from convalescent homes on the grounds that they are depressing for others to see, and because they require a great deal of care which institutions usually are not prepared to provide.

Convalescent Care As A Preventive and Pre-operative Measure

Convalescent care must be regarded as an important part of preventive medicine that should be employed to aid recovery.[2] Some thought should also be given to the diffi-

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[1] Ravdin, op. cit., p. 75.

[2] Ernest P. Boas, The Unseen Plague, Chronic Illness, (New York: J. J. Augustin, 1940), p. 8.

culty a patient on relief, or in the low income group, has in facing a surgical operation. No extensive use is made of the convalescent homes for "building up" the patient prior to an operation.[1]

Many of the factors contributing to surgical morbidity and mortality could be eliminated by improving the nutrition of patients who are to have an operation. The disruption of abdominal wounds may be due to a vitamin C deficiency, or to hypoproteinemia. The hemorrhagic tendency of patients with a serious liver disease is due to a vitamin K deficiency conditioned by an absence of bile salt in the intestine. These and many other conditions could be corrected by intelligent pre-operative care. It seems valid to make a greater use of convalescent homes for the purpose of preparing the patient mentally and physically for surgery.[2]

Nutrition As An Aid To Recovery

In convalescent care and even in hospital care of many of our patients we have failed to put into practical use, our knowledge gained during the past decade in the field of nutrition and nutritive disturbances. It has become possible to determine and formulate a basic diet which will

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[1] Ravdin, op. cit., p. 77.

[2] Ravdin, op. cit., p. 78.

contain the essential elements in sufficient quantities of vitamins and minerals, apart from caloric requirements, necessary to produce a state of nutritive balance for an individual of a given age, size and activity. Frequently, in the low income group and in various diseases, the diet of the patient prior to admission to the hospital is inadequate. In addition the strain on nutrition produced by a period of acute illness is not repaired by the proper diet while in the hospital. "In convalescence we are prone to place our patients on a routine diet which in no way takes into consideration his nutritive needs in respect to his previous dietary inadequacy or the nutrition depletion of his illness, and then send him back in a state of serious nutritive inbalance to his home where his diet may again be insufficient for his basic requirement." In other words, we are still labeling our diets as, "regular diet," "soft," "convalescent," "ulcer diet", or "colitis diet," according to the disease from which the patient is convalescent.[1]

Again we see this new thought in convalescent care, namely, the special needs of the particular individual who is seeking to regain health, rather than the convalescent care of the case of ulcer, fracture, or appendicitis, is of paramount importance.

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[1]H. D. Kruse, M.D., "Results of Recent Research in Nutrition," Convalescent Care, Proceedings of Conference, pp. 15-23.

Psychosomatic Factors Of Convalescence

In order to discuss the psychosomatic factors in convalescence it is necessary to define the field of psychosomatic medicine. This is a new branch of medicine insofar as it brings together certain symptom complexes which lie between psychiatry and other fields of medicine.

"Psychosomatic medicine is the systematized knowledge of how to study bodily functions in which emotional processes are associated and amalgamated with organic processes to form a complex of specific patterns and the treatment thereof. It tries to define the personality as seen from the point of view of bodily formation, bodily function, and bodily action."[1]

It is not an overstatement to say that fully fifty per cent of all the problems of the acute stages of illness and seventy-five per cent of all the difficulties of convalescence have their primary origin not in the body, but in the mind of the patient.[2] Convalescence from any serious illness is an overwhelming problem of psychiatry. The willingness of a physician to consider or disregard this often determines whether the patient will completely

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[1] Felix Deutsch, M.D., "Social Service and Psychosomatic Medicine," The News Letter Psychiatric Social Workers, II (Spring, 1942), 1.

[2] E. A. Strecker, "Mental Hygiene," Nelson's Loose Leaf Medical Library, (New York: T. Nelson and Sons, 1937), VII, 399.

recover or will remain handicapped for years.

The cessation of the acute stage of an illness calls for a readjustment in the thinking and attitude of both the patient and the doctor as the method of treatment changes. It is no longer the illness that needs the first consideration but the "patient as a person." This phrase is used to denote an individual with a social status, and with a conception of the role he desire to play in a group. When attention is directed to this patient, it requires some comprehension of his social setting and his personality.[1] Although a doctor usually devotes most of his thinking to the somatic aspects during an acute illness, at no time should the emotional factors involved by completely obscure.

Treatment of a patient convalescing from an illness should start from the doctor's first visit to him. He should have some explanation of his condition which will lessen his fear and protest because he knows what to expect and feels certain of his recovery.[2] Unless a patient is badly frightened by the acuteness of his symptoms, it is difficult to convince him that the prescribed period in bed is not a waste of time. It is generally known that

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[1] G. Canby Robinson, M.D., "Psychosomatic Factors in Convalescence," Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, (November, 1939), p. 129.

[2] O. H. Perry Pepper, M.D., "The Physiology and Psychology of Convalescence," Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, (November, 1939). p. 10.

some patients are hard to hold back from assuming their accustomed duties and routines.

When a person becomes too ill to carry on his regular duties, he is usually not only relieved of all responsibility for them but is encouraged by his family and doctor to cease to think about them. All sorts of barriers are used to separate the patient from his daily tasks, and various means are used to make him as dependent as possible. These are some of the efforts that are made to adjust the patient to his illness. Often these adjustments become so well fixed that a readjustment upon recovery may be difficult. It is at this time that a neurosis, quite obscured during the course of an acute disease, may begin to show its signs, and is often considered to be the result of the disease. In reality it is a recurrence of an aggravation of neurotic personality characteristics which the preoccupation by the disease has obscured.[1]

A patient's attitude towards disease depends, in a broad sense, on whether or not he was a well adjusted individual prior to the onset of his present disability.

The patient who was not well adjusted prior to his present illness, reacts in many respects as the well adjusted individual; that is, he experiences a fear common to

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[1]Robinson, op. cit., p. 35.

all people who become sick. He worries about himself, his family, and his job; but he over or under-reacts. Many poorly adjusted people welcome this opportunity presented by disease, of escaping from family, social or economic responsibilities. Many of these patients are psychologically immature. The hospital stands to them as a symbol of the mother who recognizes the dependency of her children and who neither imposes on them the usual discipline nor exacts from the social adjustment they should make. The patients in this category are poorly adjusted to begin with, not because the situations with which they are faced are different, but because they are often constitutionally different from others. Disease may exaggerate this inability. These patients need specific therapy.[1]

Dr. G. C. Robinson stresses the need for providing convalescent aid for the private patient of small means whose need for maintainance of financial solvency frequently drives him to resumption of his full activities during his illness. His anxiety over his expenses and possible loss of a job is more urgent to him than to the indigent person in the hospital ward.

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[1] Pepper, op. cit., p. 12.

Differentiation of The Chronic And Convalescent Patient

Care should be taken to differentiate the convalescent from the chronic patient. This can be done only on an individual basis and with a thorough knowledge of each. The former is definitely on the road to recovery and traveling in a direction away from his illness, while the latter is still sick, differing from the acute patient in the duration of his illness. The convalescent patient needs facilities of a stimulating nature that will help him make the best of his own recuperative powers, while the chronic patient still requires to a greater degree than the acutely ill patient those diagnostic and therapeutic facilities, including personnel and equipment. Placing a convalescent patient in a hospital for chronic disease is an organizational mistake, comparable to his retention in a hospital for acute illness. In fact, it is preferable for him to remain in the latter because he is already accustomed to that institution. The custodial type of patient, the kind that one finds in the homes for the aged, homes for incurables, or alms houses, is of course far removed from the convalescent type of patient. The one is hopelessly handicapped, the other is full of hope and preparing to return to his place in society.[1]

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[1] E. M. Bluestone, M.D., "Planning for the Convalescent Patient," Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, pp. 173-74.

CHAPTER II

TREATMENT OF CONVALESCENT PATIENTS

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It is too frequently and too complacently assumed that the time factors involved in convalescence from a surgical operation are chiefly those dictated by the duration of healing of traumatized tissues.[1] From a review of the literature on the subject, it is generally conceded that the average stay of a patient in a hospital is three weeks. But it may be stated as a general proposition that a patient ill enough to require the average of three weeks, will yet require a second three weeks, at least, of intelligent and active convalescent care before he will be prepared to resume his previous activities on a level at least equal to that which existed prior to his hospitalization.

It was observed in the United States Army during the period from December, 1917, to June, 1919, that under the usual methods of routine rapid discharge of patients from hospitals direct to full duty, there was a return to the hospital of patients incompletely relieved, totaling some fifteen to twenty per cent of all discharges from the

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[1] John Bryant, M.D., Convalescence, Historical and Practical, (New York: The Sturgis Fund of the Burke Foundation, 1927), p. 177.

hospitals. At a large convalescent camp in France there was opportunity to observe the average time of discharge of patients from hospitals direct to full duty, as compared with the time required for men carefully checked as to physical and mental progress toward real recovery by passage through a convalescent camp. It was proven that six weeks, not the usually accepted three weeks, was the time required for complete recovery of the average patient.[1] This conclusion was of value because it involved a group of 2,000 patients followed in a period of two months, and is cited for the purpose of emphasizing the value of adequate convalescent care as an integral part of medical treatment.

Case Finding Of Convalescents

Several methods have been tried in the selection of patients on surgical wards who will benefit most from convalescent care, or those for whom chronic illness may be prevented. In one instance, the chiefs of surgery, after discussion with the director of social service, and the staff worker assigned to that service, agreed to have the medical social worker interview each patient admitted to the ward with a diagnosis of peptic ulcer, without waiting for the doctor's individual referral. As a result,

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[1] Ibid., p. 179.

each patient's social study was well in hand before the question of discharge arose. A patient-worker relationship was well established and a summary of the social findings was available to the doctor for discussion. This method presented an individualized picture of the patient in relation to his illness and the possibility of carrying out the prescribed medical treatment. The detailed instruction for the patient's whole regime, is particularly important and often particularly difficult to get from many physicians who feel at a loss if asked how often the patient may walk up one flight of stairs or whether the patient would benefit by having breakfast in bed for two weeks.

In another large general hospital, the chief of each service asked that the social worker talk to every patient admitted to the wards, and as soon as possible to place on the medical record a social history containing a relatively full picture of the home environment and attitudes of the patient and his family, toward his illness. During ward rounds with the chiefs of the various services, the whole plan of treatment was discussed. Any question of the possibility of the carrying out of the medical treatment was discussed; but the major responsibility for recommending convalescent care rested upon the doctor.

There is indication in this latter plan that first, the doctors are thinking of the patients as whole human

beings and not in terms of their specific diagnosis, such as a fractured leg or a peptic ulcer; second, the medical social worker is assigned a small enough group of patients to enable her to be reasonably thorough and careful in evaluating a social situation; third, the available social information makes it practical for the doctor to weigh both the medical and social aspects of this case before recommending treatment; and fourth, the medical social worker obtains the individualized picture of the regime the patient should follow.

Although the major responsibility for prescribing convalescent care rests upon the physicians, the particular skills of the medical social worker are needed in interpreting to the patient the importance of this care as a means to recovery.[1] Having known the patient as she has during the course of his illness, and with her understanding of his social and intellectual background, she is in a better position to understand some of his conflicts in accepting his illness and in carrying out the doctor's prescription for convalescence. She is also able, with her knowledge of his social situation, to help him evaluate his resources and to determine how he might receive the best care.

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[1]Elizabeth G. Gardiner, "Convalescent Case Finding," Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, (November, 1939), pp. 167-169.

The present methods in many hospitals, on the other hand, in deciding who is to have any considerable amount of convalescent care have been too haphazard to be called selection. Frequently, a doctor who wants a bed for an acutely ill patient, or wants to rid himself of a patient he cannot help, orders his discharge. If the individual makes no complaint regarding his ability to provide for his own convalescence, he is discharged. If, on the contrary, he states he has no place to go, he is referred to the medical social worker, who has often not previously known the patient. In other words, the plan for convalescence is left entirely to the judgment of the patient or his relatives without the help from the physicians of the medical aspect of his condition, and the medical social worker of the social aspect of the situation. This is true whether the form of care suggested is institutional convalescent care, a visiting nurse, visiting housekeeper, temporary foster home placement, or a combination of all of these.[1]

In some instances the medical social workers are forehanded enough to approach the chiefs of the various services shortly after the patients' admissions to the wards in an effort to determine the extent of their illness and the type of after care they will need. This procedure is not

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[1] Ibid., pp. 165-166.

objectionable provided the doctor does not shift on to the social worker all responsibility for the interpretation to the patient of his illness, his limitations and his plan of treatment following his discharge from the hospital. On the other hand, the social worker, with her knowledge of social factors which influence recovery from an illness should not depend entirely on referrals from the doctor. There rests a joint responsibility with both the medical and social work profession, working together for the good of the patient in such a way that he might benefit most from his medical treatment.

Recently, the dean of the Medical School of Syracuse University wrote that the preparation of medical students needed to include planning for the phases of treatment carried on after the patient left the ward and went home.[1] When the young doctors have learned the value of adequate convalescent care during their internship or residence, they are much more likely to try to prescribe it when they become practicing staff physicians.[2]

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[1] A. A. Bailey and H. G. Weiskotten, "Problems of the Discharged Hospital Patient," Hospitals, (1939), p. 3.

[2] Elizabeth G. Gardiner, "Convalescent Case Finding," Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, (November, 1939), p. 169.

Home Convalescence

The care of patients in their own homes during convalescence, by medical social workers and visiting nurses, is an important division of convalescent service. As early as 1920, in the Cleveland Hospital and Health Survey, the necessity for provision for "Home Convalescence" as well as institutional care was emphasized: "An institution is not the ideal place for convalescence from disease. The home, when conditions are satisfactory is the ideal place."[1] There has been a growing tendency to keep dependents of all sorts out of institutions and to maintain them in their own homes. It is felt that an adult, crippled by illness should not be forced by economic reasons alone, to bear the added burden of separation from his family and friends, and be registered in an institution. With a certain amount of public assistance many patients could remain at home and be well cared for. Often this is the happiest solution for the patient and for his family.[2]

At the time of the patient's discharge from the ward the medical social worker can assist in instructing the patient in carrying out his medical treatment. In many communities the family welfare agency is equipped with a staff to give consultation and guidance on home management,

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[1] Bryant, op. cit., p. 187.

[2] Boas, op. cit., pp. 76-77.

hygiene and diets. Without such assistance many families are either not able or not willing to carry out the necessary routine for the patient outlined by the physician.

The provisions of visiting housekeepers, to assist mothers convalescing at home is a practice that is growing. Outstanding examples of this are the housekeepers provided by various private welfare agencies and by the Work Projects Administration. In many instances, the family life would be otherwise disrupted, and children separated with resulting anxiety to the convalescent mother. This service is applicable both in acute illness and in convalescence, during temporary absence of the mother in a general hospital, during the temporary absence of the mother in a convalescent institution or when she can be suitably cared for at home.[1]

The practice of boarding patients in foster homes for convalescence, although still rare, is growing and is being advocated increasingly. The advantages of this method for children under certain conditions have been demonstrated by the Speedwell Society in New York, which maintains eight units, each composed of a number of boarding homes, providing in all, over 200 beds, carefully chosen and strictly supervised. At the Children's Hospital in Boston, a careful and discriminating use of foster home convalescence has been

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[1]Jarrett, op. cit., p. 17.

made possible through child welfare agencies.[1]

"Home is intensely personal. It is what it is because the occupants want it that way. It is the place where our patient normally solves his problems under conditions favorable to his own particular personality. It is the environment he best understands, the one in which he will continue to live, and to which he will respond with a minimum of conflict."[2] It may be a place quite different from what we think it should be, but it does something for him that no other home can do.[3]

Institutional Convalescence

When it has been determined that the patient's home is unsuitable for his period of convalescence for reasons of poor housing, inadequate sanitary facilities, economic conditions or because of his status as a homeless individual, then he becomes our concern either for institutional placement or boarding home care. Some patients can afford care in private convalescent homes. They are not our immediate concern. But the patient who needs and cannot afford the care he requires, belongs in the rank of dependents. He is

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[1] Mabel R. Wilson, "The Medical Placement of the Child Outside His Own Home," Hospital Social Service, (January, 1931), pp. 13-23.

[2] Pepper, op. cit., p. 12.

[3] Pepper, op. cit., p. 14.

as much a charge on the public as the aged, the unemployed, and those who are classified as infirm.[1] It should not be compulsory for him to accept care in a public institution but a private boarding home should be offered to him as an alternate plan.

Dr. Haven Emerson's Survey of Hospitals and Health Agencies of Louisville, 1924

In 1924, Dr. Haven Emerson conducted a survey of hospitals and health agencies of Louisville. At that time, it appeared that the bulk of patients cared for in the voluntary hospitals were pay patients entirely able to meet the needs of their convalescence. The main problem was among the group at the General Hospital. A hospital policy limited the stay of patients in the institution to two months, but in many instances they were allowed to remain much longer because home conditions did not afford the facilities needed for proper convalescence.[2] At the time of this study there were no facilities for institutional convalescence other than placement in the Alms House.

A census of all patients in public and private hospitals on a given day indicated the size of the group

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[1] Bluestone, op. cit., p. 176.

[2] Haven Emerson, M.D., Hospitals and Health Agencies of Louisville, Survey made for the Health and Hospital Survey Committee of the Louisville Community Chest, 1924, p. 164.

for which institutional convalescence was needed. A conservative estimate of one hundred convalescing patients in hospitals was made. It was generally assumed at the time of they survey that approximately twelve per cent of the total number of hospital patients required care in a convalescent institution.[1]

Dr. Emerson undertook a study of patients discharged from eight Louisville hospitals during a four week period, with sufficient medical and social data to serve as a guide for selection of a representative group for home visits. The group included male and female patients of all ages, color, economic status, and medical condition. It was found that many patients were retarded in their return to health and usefulness because of undesirable home conditions. Many had returned home to take up family burdens before they were able, others were trying to get well in forlorn rooming houses without medical or nursing care, and still others, homeless and without adequate financial resources, were dependent upon friends who could take them in until they were able to go back to work. Patient after patient presented a waste of medical and hospital service in delayed recoveries, relapses, readmissions to the hospital, and inability to take up their actual responsibilities of

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[1] Ibid., p. 150.

home and work. These patients revealed a very incomplete community job of human salvaging.[1]

It was recommended that a committee representing the Jefferson County Medical Society, all the hospitals and other health organizations and the social agencies, would be the logical way to conduct further inquiry into the subject and to frame a community policy dealing with various phases of a complete program for convalescent care.[2] The author is unable to find a record of any action taken on these recommendations.

In 1940, the W.P.A. made a survey of the out-patient clinics at the Louisville General Hospital. It was noted that twenty-seven per cent of the patients admitted to the wards from the clinics and dismissed, were readmitted within one month, thirty-nine per cent of such patients were re-admitted from two months to one year, and thirty-four per cent after one year or more. Thirty-six per cent of those admitted to the wards within one month, and fifty-two per of all such patients were apparently readmitted with the same diagnosis. Of the patients readmitted within one month of their first dismissal, with the same diagnosis, fifty per cent were surgical, eighteen per cent were obstetrical, fifteen per cent were children, fourteen per cent were

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[1] Ibid., p. 148.

[2] Ibid., p. 151.

medical, two per cent were psychopathics, and one per cent were isolation cases.[1]

Dr. A. C. Bachmeyer of the University of Chicago, Division of Biological Sciences, made a survey of the Louisville General Hospital and Waverly Hills in May, 1942, following the merger of the county and city health facilities. His comment on the above statistics from the clinic survey was, "The statistics might well raise the question whether some of these patients had not been dismissed too soon with detriment to themselves and consequently additional cost to the institution. It may well be that lack of convalescent facilities, for which there is apparently great need, may be to a large measure responsible. The findings, as set forth in the clinic survey, are deserving of serious consideration."[2]

Financing Convalescent Care

Little is known yet about the comparative costs of the various forms of institutional and non-institutional convalescent service and the extent to which they are suitable for different groups of patients. The cost of both

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[1] General Hospital Clinics Survey made by Works Progress Administration, 1940.

[2] A. C. Backmeyer, M.D., Survey of the Louisville General Hospital and Waverly Hills Sanitorium, May, 1942, p. 10.

construction and maintenance for institutional convalescent care is roughly one third to one half the cost of hospital care. The cost of organized convalescent care for patients who could be cared for suitably in their own homes or in foster homes would probably be less than the cost of institutional care; and in addition the capital cost would be saved.[1]

In the Hospital Survey conducted by the United Hospital Fund of New York, 1934, of all convalescent homes serving the New York metropolitan area, it was found that the cost of institutional care averaged $2.05 per patient per day, exclusive of depreciation, and $2.35 if that item of expense was included. The survey disclosed that of the total income received by the homes, only nine and three-tenths per cent came from the patient's payment. The average of nine and three-tenths was compared with that of sixty-three and eight-tenth per cent, representing the proportion of the total income from patients. The most important reason for the difference was that the convalescent homes served mainly the sick poor who could pay little or nothing for their care, and whose home conditions were not suitable for a period of convalescence.[2]

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[1]Jarrett, op. cit., p. 18.

[2]Arthur W. Jones, "Financing Convalescent Care", Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, (November, 1939), pp. 216-218.

In all communities outside of New York City the seeming neglect of convalescent patients is due to the lack of funds for such a program. It is natural that the provision of care for the acutely ill person should take precedence over provisions for facilities for the convalescent patient. But even in these smaller communities, Mr. Bleecker Marquette has pointed out certain steps that can be taken to inaugurate a program for convalescents without a great outlay of money. First, those responsible for the care of the sick, particularly physicians, need to have a better understanding of the problem of convalescence and familiarize themselves with available resources. Second, more consideration should be given to the plan of adapting already existing facilities for convalescent purposes. Third, the recommendation that the provisions of the Workmen's Compensation Act be expanded to include convalescent care should be made effective. Fourth, that hospital prepayment plans should make provisions for convalescents as well as those in need of hospitilization for an acute illness. Fifth, that the National Health Program should direct its attention to the need for convalescent facilities, indicating that the fact must be faced that this is a public obligation which will not be met without government subsidy, since in all likelihood, private philanthropy cannot be counted upon to the extent that it has been in

the past. Finally, those communities which are unable at the present time to finance an adequate convalescent program, can at least map out the pattern which such a program should assume, and make a beginning, no matter how small.[1]

Louisville may be included with the majority of other cities of its size, which have evidenced neglect in developing a community program for the care of convalescents. We are especially aware here of the lack of institutional facilities. A review in the following chapter of the development of the Louisville General Hospital and the Home for the Aged and Infirm gives insight to some of the problems which confront these institutions in caring for the convalescent patient.

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[1]Bleecker Marquette, "Financial Aspects of Convalescent Care," Convalescent Care, Proceedings of the Conference of the Committee on Public Health Relations of the New York Academy of Medicine, (November, 1939), p..222.

CHAPTER III

THE EARLY DEVELOPMENT OF CONVALESCENT CARE IN LOUISVILLE

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We have shown earlier that, in many of the European countries a program for the care of convalescents was well on its way by 1850, and it was not until 1872 that the United States made a beginning. By 1925, considerable progress had been made within New York State, but the remainder of the country continued to lag behind, having either no facilities for convalescence or using substitute arrangements that did not meet the need. Louisville was included in the latter group.

The History and Development Of The Louisville General Hospital

In the early part of 1800, Louisville was establishing itself as a municipality. The site of the city on the Ohio River brought to the community extensive trading and transportation. Very soon, because of the many mariners who fell sick due to long voyages and exposures, the need for a hospital was recognized. At first, the citizens assumed the responsibility of caring for those persons, but it became apparent with the growth of the city, and the prominence which the town was acquiring in the field of commerce,

that the problem could no longer be cared for merely by the good will of the people of Louisville. On February 5, 1817, at a time when the population of the city numbered about 4,000, an act of the General Assembly of Kentucky was passed for the establishment of the Louisville Hospital Company.

From 1817 to 1836, the institution was administered by a "body corporate and politic". During this early period the city had already begun to realize the need of some place for the isolation of contagious disease. A health department was set up in 1822 to cope with the dreadful epidemic of yellow-fever which was spread throughout the West. Louisville, however, was severely affected because of a lack of adequate sanitary facilities. The town became known as "the graveyard of the West".

Because of successive epidemics, the city administration was awakened to action and a Department of Health was appointed to determine the cause of the prevalence of yellow fever in the community and to suggest methods of control and eradication. Had this department been established earlier, much suffering might have been prevented, but already epidemics of fever had made great inroads in the population.

By 1830, the population of Louisville had grown to 10,341, and in respect to numbers, Kentucky ranked sixth in the Union. Louisville was no longer dependent on river

trade as it had been. Such industries as casting of iron for mills and steamboats, tobacco, pork packing, and crude lumber and flour mills developed. These activities brought permanent residents to the city.[1]

The city officials had been for some time aware that the protection of public health was one of the first duties of the government. In order to meet further the needs of the community, it was evident that municipal institutions must be set up. Accordingly, by an Act of the Legislature, February 29, 1936, the operation of the Louisville Marine Hospital[2] was given over to the Mayor and Council of the City of Louisville. They were to annually appoint a Board of Trustees to make rules and orders for the governmental management of the institution, and to employ a keeper, health officer, physician, maids, nurses, and attendants.

In the ensuing years, the scope of the hospital was greatly broadened through affiliation with the Medical School of the University of Louisville; the admission of pay patients which provided a source of revenue to the city; the acceptance of the responsibility to care for the freed negro;

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[1]Louise H. Meyers, "A History of the Louisville City Hospital," (Unpublished M.A. Thesis, Department of Sociology, University of Louisville, 1936), pp. 7-20.

[2]Note change of name from Louisville Hospital Company as provided for by and Act in the City Charter approved February 13, 1828.

the provision of medical and surgical care free of charge topersons who, because of poverty, could not otherwise procure care; the establishment of dispensaries in the eastern and western sections of the city; and through improvement and enlargement of provisions.

Since 1822 the hospital has been under the administration of the Board of Public Safety of the City of Louisville. On March 15, 1942, by an act of the General Assembly, the Louisville and Jefferson County Board of Health was organized to meet the health needs of the community. At this time the Louisville City Hospital became the Louisville General Hospital.[1]

Relation Of The Home For The Aged To The Present Program For Convalescent Care

Since the Home for the Aged played a rather active part in the medical program, it is appropriate to review briefly its early beginning and growth. There is evidence in the annual reports of the Louisville General Hospital and the Department of Public Welfare that frequently patients were transferred from the hospital to the Home for the Aged and Infirm, because of the crowded conditions in the hospital

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[1] At the regular session of the General Assembly of the Commonwealth of Kentucky, 1942, Senate Bill No. 35, the city and county health departments merged and became the Louisville and Jefferson County Board of Health. The Board is appointed by the Mayor of Louisville and the County Judge of Jefferson County. The Director of Health is appointed by the Board of Health.

wards. Although these patients were not directly referred to as convalescents, it is assumed that they needed continued nursing care.

There are no records to indicate exactly when the first poorhouse was built, but it is known that a combined poorhouse and workhouse was in operation as early as 1832. The building accommodated the poor of the city as well as the sick. An ordinance of the Charter of 1851 entitled "An ordinance for the Regulation of the Louisville City Almshouse" was of importance since it affected the Home and resulted in many important changes in administration, financial management, and specifically included provisions for more adequate medical care for residents of the Almshouse.[1]

Although the institution was always staffed with personnel for medical care, the framers of the legislation apparently felt this so important that one section stated that the General Council was to provide for the election and appointment of all "needful nurses and attendants of the Almshouse." Another provision of the Charter of 1851 specifies that the General Council was to confer responsibility for the medical care of the Almshouse upon the

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[1]Irving M. Lipetz, "The Louisville, Kentucky Home For The Aged And Infirm," (Unpublished Master's Thesis, Graduate Division of Social Administration, University of Louisville, 1942), pp. 9-10.

elected physician of the western district of the City. This physician was to treat all indigent residents free of charge.[1] Another required that the physician visit the institution at least once a day and as often as the condition of the inmates required it day or night. He was to prescribe for the sick and see that the nurses did their duty in all respects.

The physicians' annual reports were importance since they indicated that those men were constantly striving to improve the medical care of the patients. In 1886, Dr. R. C. C. Jones, the attending Physician, reported that there was little illness and that most of the cases were chronic. The most important need from a medical standpoint "was a ward, or a room in which patients needing special treatment might be placed, at one end of which a small room should be partitioned off for an examining room. The toom could be used for a lying in room if necessary, in consequence of the crowded conditions of the wards. The sick and the well are now necessarily kept together."

Dr. Jones' statement of the transfer of patients from the City Hospital is the first mention of a practice which has continued up to the present time. The City Hospital had been enlarged periodically to meet the con-

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[1] Ibid., p. 26.

stantly increasing demands for hospital care. The hospital had been able to care for the acutely ill, but its facilities had not permitted the admission of the chronically though not acutely incapacitated patients. This latter group included those suffering from various heart diseases, cancer, and general infirmities accompanying old age. Surgical cases involving long time bed care were also often included. This lack of bed space, equipment and medical personnel, had caused many persons needing medical care to apply for admission to the Home.[1]

The annual report for 1930, indicated that a physician was employed to spend a part of each day at the Home making medical examinations. This medical aid had long been needed and again it was reported that the plan greatly relieved the congested condition of the City Hospital, to the extent of an average of fifteen patients a day. At this time there were two hospital wards in the Home, one for white men and one for white women.

Dr. Franklin Jelsma, in his annual report of the medical department of the Home in 1931 and 1932, clearly reviewed the problem of medical care in the institution, and presented the plan of convalescent care of patients leaving the City Hospital. This same program is in existence today and is significant in that the Home is the only tax

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[1]Municipal Reports, Louisville, Kentucky, 1886.

supported institution available to care for convalescing patients.

As a result of the difficulty in the past of transporting patients who were inmates of the Home, to the various clinics at the hospital, a hospital division was set up. In the beginning separate hospital facilities were available for white women, and white and negro men. The negro women were congregated into one room. Dr. Jelsma's report stated that the hospital wards were thoroughly equipped, well heated and well ventilated. They were furnished with hospital beds, and up to date fixtures and appliances.[1] In 1932 there were hospital accommodations for seventeen white men, nine negro men and sixteen white women.[2]

By an agreement, in 1931, between the Department of Health, the Dean of the School of Medicine, University of Louisville, the Director of Welfare, the Superintendent of the Home for the Aged, and the Medical Advisor for the Home, patients convalescing from an acute illness or those of a definite chronic nature were transferred from the General Hospital to the hospital division of the Home for the Aged. This procedure made it possible to free the beds

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[1] Annual Report, Department of Public Welfare, Louisville, Kentucky, 1931.

[2] Annual Report, Department of Public Welfare, Louisville, Kentucky, 1932.

at the General Hospital for patients in need of specific hospital treatment.[1] Chronic patients are no longer transferred from the General Hospital to the Home, but are referred to the Municipal Bureau of Social Service for placement as inmates of the Home.

There was a steady increase in the number of chronically ill patients admitted to the Home as inmates, who needed nursing care which could be given only on the hospital wards. As a result the hospital was filled to its capacity which meant that beds were seldom available when needed, for patients awaiting transfer from the General Hospital for convalescent care. Out of this situation developed a plan to reserve twenty beds for the use of patients in need of convalescent care. The purpose was sound but the plan was not practical, for chronically ill patients continued to enter the Home with no increase in facilities to take care of them. They occupied the beds which had been reserved for the General Hospital. The convalescent patient therefore remained on the wards at the General Hospital until a vacancy was available.

The procedure for transfer of a patient to the convalescent ward involves, first, the referral of the patient to the medical social service department, and second, a

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[1] Annual Report, Department of Public Welfare, Louisville, Kentucky, 1931.

review of the patient's social situation to determine whether he is in need of this care. If the patient's home situation indicates that he cannot be adequately cared for, a request for his transfer to the convalescent ward from the Louisville General Hospital is made to the Dean of the Medical School. These persons are technically patients of the General Hospital and are counted in the daily census until the time of their discharge by the medical staff at the Hospital.

Size and Equipment Of The Hospital Ward At The Home For The Aged and Infirm

Since the Home for Aged and Infirm is the only tax supported institution offering convalescent care, it is well to review its facilities. The Home is a large three story, grey brick building located at Shively, Kentucky, about five miles from downtown Louisville. The hospital division, located on the first floor, is the only part of the Home with which we come in contact. All male patients occupy the South end of the hospital and the women are housed in the North end.

There are eighteen hospital wards accommodating a total of ninety-three patients, with no provision for segregation of chronic and convalescent patients. The distribution of beds is shown in Table 3. The importance of segregation of these patients was pointed out above.[1] Each unit by sex

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[1] Supra, Chapter 1, p. 28.

and color is equipped with a bathroom, and diet kitchen (not actually a diet kitchen, but for the purpose of disbursing food prepared in the central kitchen). The only room equipped with fracture beds (special) is on the male white ward, however, these beds may be transferred where needed. There is one treatment room where minor surgery may be done, one nurses' office, where medical records are kept, and a drug room. The hospital wards are fairly well equipped and ventilated but generally overcrowded. The census of the Home on August 18, 1942, was 262 persons. Ninety-three of these were hospital patients (the capacity), and three of the ninety-three persons were convalescent patients transferred from the Louisville General Hospital as convalescents. The daily average population of the Home in 1941 was two hundred, thirty-six, who were kept at a cost of sixty-seven cents per patient per day. This cost does not include depreciation.

TABLE 3

DISTRIBUTION OF BEDS BY RACE AND SEX
IN THE HOSPITAL DIVISION OF THE HOME FOR THE AGED, 1942

Race	Total	Male	Female
Totals	93	52	41
White	56	36	20
Negro	37	16	21

As already indicated, twenty beds in the hospital ward were assigned to the General Hospital for patients needing convalescent care which could not be adequately provided in their own homes. That number of beds, however, is seldom actually available because of the large number of inmates at the Home, chronically ill and in need of nursing care available only in the hospital division of the Home.[1]

In Table 4 we see the results of an interesting and highly significant survey of all inmates in the Home in January, 1942. The twenty-four residents who had been known to Old Age Assistance represented those persons who had been receiving grants but who needed medical care, as well as those who had applied for grants but whose applications had been rejected. The fifty-seven residents who were referred by the General Hospital included those patients who had been acutely ill and whose diagnosis indicated they would require either permanent hospital care or care over a longer period than generally required in convalescence. Each of the two hundred and twenty-two inmates, referred to in Table 4, was discussed with the social worker at the Home and it was learned that approximately fifty per cent of the group were in need of constant medical care.[1]

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[1] Lipetz, op. cit., pp. 94-95.

[2] Ibid.

TABLE 4

AGENCIES WHICH ASSISTED RESIDENTS OF THE HOME FOR THE AGED AND INFIRM ON JANUARY 1, 1942, PRIOR TO DATE OF ADMISSION

Agencies	No.
Total	222
Municipal Bureau of Social Service	93
Louisville General Hospital	57
St. Vincent de Paul Society	2
Family Service Organization	38
Old Age Assistance	24
Central State Hospital	4
Salvation Army	2
Juvenile Court	2

Personnel of the Home

The personnel includes the Superintendent of the Home, who is a registered nurse, a second registered nurse, and a visiting physician designated by the Department of Welfare, who visits the Home every Monday, Wednesday and Friday and who is on call at all times. He sees only those patients referred by the head nurse and the junior and senior medical students. A junior and senior medical student are employed by the Department of Welfare, and are on duty from 6 p.m. to 6 a.m. A druggist visits the Home twice a month and prepares those drugs which cannot be

purchased or secured through the drug department of the Louisville General Hospital. The Work Projects Administration had a health project employing ten persons. They are: a foreman, one seamstress, one laundry helper, one cleaner, two laborers, and four ward helpers.

A social worker appointed by the Department of Welfare, is assigned full time to the Home for the Aged. It is her responsibility to assist the inmates of the Home in meeting those problems which might arise with him during his stay there. The medical social workers on the staff at the General Hospital who are in contact with convalescent patients before their transfer to the Home and who are already acquainted with the individual situations of each, continue their services to the patients as long as they are on the convalescent ward. They attempt to visit the patients usually once a month while at the Home. This may appear to be only a friendly visit and yet is planned and serves as a component to the medical treatment he is receiving. Upon the patient's return to the parent hospital clinic for follow-up care, the medical social worker is there to help him bridge the gap between the convalescent ward (which the patient feels is detached from the hospital) and the clinic. She assists him in verbalizing his physical complaints to the doctor, and represents to him a tie to the community. She assists him also, in meeting any personal or family problems which might be interfering with his recovery.

Medical Records

All patients transferred from the General Hospital to the Home are accompanied by their medical charts and treatment is recorded while there. When the patient is discharged by the Hospital and he leaves the convalescent ward, his medical chart is returned to the record room at the hospital.

Resistence To Transfer To The Home For The Aged And Infirm

Although patients on the convalescent ward are technically patients of the General Hospital, they often resist transfer there. The majority of patients approached by the doctor or the medical social worker in regard to convalescent care know very little about available facilities. They, as a rule, have little idea of the value of the convalescent home in expediting recovery. To many of them the mere name "convalescent home" implies an extension of charity which many are loathe to accept. One of the most difficult problems the medical social worker at the hospital faces is the refusal of the patient to accept convalescent care at the Home for the Aged and Infirm because of the stigma attached to the institution as an "almshouse". The following letter was received from Mrs. H., abstract thirty-two[1] after she was transferred to the Home;

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[1]See appendix for abstract thirty-two.

Almshouse,
Louisville, Kentucky

> "Over the Hills to the Poor House" I have unthoughtedly sung many times, not ever realizing that I was destined to wend my weary footsteps over the "hills" terminating with the tragic culmination, "almshouse". Had I been alert enough to know where I was being brought, I am sure the result would have been different. With good lineage, splendid opportunities, two degrees to my credit, and a life of activity, thru all phases of circumstances, this is where I land.....

Interpretation of the convalescent ward, as an extension of the hospital, where adequate medical and nursing care are available has been the means of helping the patient to overcome the stigma attached to the institution.

Among other objections to going to the Convalescent Ward is the patient's fear of being so far away from his family and his doctor. When attempts are made to interpret convalescent care as an extension of surgical care, patients frequently object because new doctors will not be familiar with their condition. There is much to be said for this point of view. During the period of recovery from the operation, the patient has learned to depend on the surgeon, his assistants, and the house staff. The humanizing influence in surgery may here have its drawbacks, but would it not be better if the convalescent home was close enough to the General Hospital, so that a member of the staff familiar with the patient could visit him during his

convalescence?[1]

An attempt will be made in the following chapter to survey the available community resources for the convalescent care of patients leaving the surgical wards at the Louisville General Hospital.

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[1]Ravdin, op. cit., p. 77.

CHAPTER IV

A SURVEY OF LOCAL FACILITIES FOR THE CONVALESCENCE OF SURGICAL PATIENTS

CHAPTER IV

A SURVEY OF LOCAL FACILITIES FOR THE CONVALESCENCE OF SURGICAL PATIENTS

This study of available facilities for the care of patients during convalescence from a surgical operation was preceded by a survey in 1924 under the direction of Dr. Haven Emerson of the College of Physicians and Surgeons of Columbia University. His efforts were directed toward the Hospitals and Health Agencies of Louisville, and resulted in the following recommendations: that a committee representing the Jefferson County Medical Society, all of the hospitals and other health organizations and the social agencies be formed to conduct further inquiry into the subject of convalescent care, and to frame a community policy dealing with these various phases of the program.[1] Apparently no action was taken on Dr. Emerson's recommendation.[2] Again, in March, 1939, a survey and appraisal of all Community Chest Agencies was made under the direction

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[1] Emerson, op. cit., p. 151.

[2] Review of the correspondence in the Health Council, Community Chest Agency and Conference with the Secretary of the Council of Social Agencies failed to reveal any action on the recommendations made by Dr. Emerson.

of the Survey Committee of the Louisville Community Chest. They assumed no responsibility for an analysis of public tax supported programs, and yet it was necessary to refer to gaps and inadequacies in public agencies in order to define the responsibilities of the Chest groups. They too pointed out the very real need for adequate facilities for the care of convalescents and finally made the following recommendations:

> First, that the Children's Free Hospital change its emphasis from the care of acute pediatric cases to the care of convalescent and chronic children from Louisville and Jefferson County, but that it continue to provide such services as may be necessary for crippled children from any part of the State. The hospital should set aside at least fifty-five beds for convalescent and chronic care, thus leaving twenty beds for crippled children.
>
> Second, that the Home for Incurables change its present plan of caring for several types of patients and devote itself to the care of convalescent and chronic adults of Louisville and Jefferson County. They should then obviously change their name, and no longer care for incurables. In thus changing its program, the Home for Incurables with the aid of other social agencies in Louisville should urge the State of Kentucky to face its responsibility for the care of needy incurables and chronics.
>
> Third, that the Home for the Aged and Infirm should be changed to a home for incurables, but with a new name that should not call public attention to the type of patients cared for. The Home for the Aged and Infirm should evacuate its well old people to private homes, retain its hopeless cases, and refer such cases as are hopeful chronics and convalescents to the institution for the care of chronics and convalescents, which is recommended to take the place of the present Home for Incurables.
>
> If the plans for changing the emphasis of the Children's Free Hospital from acute pediatric care to convalescent and chronic pediatric care were put

into effect, the Jewish Children's Home would no longer be needed for convalescent white children.

Fourth, that until such plans were put into effect the medical staff of the City Hospital and the Children's Free Hospital should provide medical supervision for the Convalescent Home free of charge.

Fifth, that the Community Chest should make provision for convalescent care for colored children in boarding homes.[1]

The recommendations made in this Survey of 1939, involved a drastic change of policies for four agencies; namely, the Home for Incurables, the Home for the Aged and Infirm, the Children's Free Hospital and the Jewish Convalescent Home for Children. Obviously, without some social force behind such recommendation, we cannot hope for a revision of these policies. With the entrance of the Public Assistance program for the Aged, there has been a decline in the number of admissions of well old persons to the Home for the Aged and an increase in the number of chronically ill persons to the institution. This trend is seen in other communities also, and is responsible for the conversion of many Homes for the Aged to Chronic Hospitals.

The only direct action taken on the recommendations made following the Community Chest Survey, was an expansion of the program and policies of the Children's Agency. At the time of the study, boarding home care for convalescent children was arranged in only a few special cases. Now, the

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[1] The Louisville Survey Summary Report of the Louisville Community Chest, March, 1939.

Agency's appropriation provides for foster home care for both negro and white children, who cannot be adequately cared for in their homes because of social or economical factors. It accommodates that group of children also who are ineligible for care at the Jewish Convalescent Home because of specialized care needed and also because they are over thirteen years of age. The children are granted follow-up care in the out-patient clinics of the General Hospital. This program of foster home convalescent care has been successfully tried in many communities and is expanding here. It is the only available program in this community for the convalescence of negro children outside of their own homes.

In October, 1937, plans were drawn up for a tax supported chronic disease hospital, and it was intended that patients needing institutional convalescent care following their discharge from the General Hospital should also be eligible for care there. Because of Louisville's inability to finance this project, it has been placed for the time being in the Health Department's post-war program.[1]

The foregoing studies have dealt specifically with the general problems of convalescent care in this community. The following study was undertaken in an effort

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[1] See Appendix IV for description of proposed Convalescent and Chronic Hospital.

to ascertain the extent of the problem of convalescent care for patients discharged from the surgical wards at the Louisville General Hospital with emphasis on the following factors. First, what type of care did these patients need and what were they receiving? Second, did these patients desire a different type of care from that which they were receiving? Third, what effect was the type of care they were receiving having on their recovery? Fourth, what were the social and economical factors influencing their convalescence? Fifth, what available institutional and community resources were there to meet their needs.

Two different approaches were used in the selection of cases for the study. First, to review and analyze fifty cases known to the Social Service Department at the Louisville General Hospital. Second, to visit within a week following discharge twenty-five persons selected at random from the Discharge Report in an effort to determine what type of convalescent care they were receiving.

Since a social record is kept on only those cases which present some problem at the time of their discharge, the field for the first approach was limited. By specific problem is meant those social, economic and emotional factors which interfere with the patient's ability to carry out the doctor's prescribed plan of treatment. A review was made of the social worker's monthly reports on

the surgical service between March, 1941, and March, 1942. This period was selected for convenience because of the time the study was begun. The fifty cases represented twenty-eight per cent of the total number who needed some form of supervised convalescent care. By supervised convalescent care, we mean care in an institution, public or private, or in the patient's own home with the aid of community resources such as a visiting housekeeper, visiting nurse, or service from a public or private welfare agency. The schedule used in the study of this group directed attention to such identifying information as age, color, marital status, diagnosis, and social and economic factors.[1]

After completing the above survey, the author realized that this group of fifty cases represented those persons who presented obvious problems and that there were possibly many patients leaving the hospital, who on the surface needed no assistance in planning for their post-hospital treatment but who in reality were also in need of some guidance. It was out of this concern that an additional study of twenty-five cases was made.

A second schedule was set up to survey many of the same factors covered in schedule one with additional inquiry into such problems as housing, income, and the patient's own

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[1] See Appendix I, Schedule 1, for copy of the Schedule used in analysis.

method of meeting his plan for convalescence.[1] Since the author had had some routine contact with most of the patients during her regular ward rounds, she was received as a visitor and the information was readily given. It is agreed that the total number of cases chosen for this study is small. However, it is felt that some of the findings are significant enough to indicate the extent of the problem for this group. From a review of literature it is agreed that any patient experiencing a surgical operation needs convalescent care. The extent of the illness and the patient's social situation determines the extent of the problem with each individual.

Table 5 on the Movement of Population indicates that from July, 1941, to July, 1942, 11,539 persons were discharged from the Hospital. From March 1, 1941, to March 1, 1942, 5,025 patients were discharged from the surgical wards. This number also included those surgical patients on the children's wards.

Findings From Survey Of Fifty Selected Cases

It is important to refer to Table 5 as an index to the volume of medical treatment of hospital patients from 1938 to 1941. There was an average stay of twelve and three-tenths days per patient, while a review of literature

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[1] See Appendix I, Schedule 2, for copy of Schedule used in Survey.

considers the average stay to be two weeks. There was a graduatl increase in admission of patients to the wards, with a marked decrease in the death rate. During this same interval there was a slight decline in the average stay on the ward. This may be interpreted as reflecting better service or as is more likely in this instance it may reflect the earlier dismissal of patients because of the urgent demand for accommodations. The latter deduction appears the more logical because of the high percentage of occupancy reported and the overcrowded condition of some wards.[1]

It may be noted also that the average cost per patient per day increased from $2.61 in 1938 to $3.20.[2] This might indicate better care of the patient since the All Commodity Price Index on January 1, 1937, was 84.3 and on January 1, 1940, was 78.3 indicating an actual decline in commodity costs during this period.

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[1] Bachmeyer, op. cit.

[2] Average cost per patient per day in 1941.

TABLE 5

MOVEMENT OF THE POPULATION OF THE LOUISVILLE GENERAL HOSPITAL BETWEEN JULY 1, 1938, AND JULY 1, 1941

Movement of Population	1937	1938	1939	1940
Patients Admitted	11,959	12,013	12,422	12,354
Patients Discharged	11,048	11,160	11,499	11,539
Patients Deceased	916	876	891	838
Patients Any One Day	497	468	489	489

Costs of Institutional Convalescent Care

The Hospital Survey for New York, sponsored by the United Hospital Fund of New York City made a survey in 1938 of the facilities for organized convalescent care in the New York metropolitan area. It was stressed that adequate facilities for convalescent care is an important factor in influencing costs. The Survey found that those homes with the most complete facilities had an average cost per patient day of $2.34 as compared with $1.86 for homes with medium facilities and $1.81 for homes with minimum facilities. As might be expected from the nature of the services which they must be staffed to render, orthopedic homes showed a relatively high cost, averaging $2.59 per patient day. Average per patient day costs for other types of homes were: general convalescent care, $2.03; neurological, $1.96, and heart diseases, $1.88. With the average costs for the

convalescent homes as a guide, it appears that to provide a reasonable high standrad of care in all these homes the cost would average about $2.50 per patient day exclusive of depreciation.[1] In the Cleveland Hospital and Health Survey made in 1924 the conclusions were that a per capita cost of $1.75 might be expected.[2]

The average daily cost per person at the Louisville Home for the Aged and Infirm in 1941, exclusive of depreciation, was sixty-seven cents. This cost does not isolate the patients in the hospital division where the expenses are greater. Due to the administrative set up the cost of caring for the patient cannot be estimated.

It is appropriate to include at this point the cost of maintaining a convalescent patient on the ward at the General Hospital in the absence of adequate bed space. As indicated above, patients are transferred to the convalescent ward at the General Hospital, and are included in the Hospital census. Because of the limited number of hospital beds, it is usually necessary to retain the patient on the hospital ward until space is available at the Home. Of the thirty-three patients included in this study who were transferred to the convalescent ward, there was a waiting period

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[1] Hospital Survey for New York, United Hospital Fund of New York, 1938, Vol. 3.

[2] Bryant, op. cit., p. 96.

of from one to fifty-seven days from the time the request for transfer of the patient was made until he was actually removed to the Home. There was a total waiting period of three hundred and thirty-nine days or an average wait of ten days. The cost of remaining on the ward at the General Hospital at the rate of $3.20 per day was $1,084. Although we do not know the actual cost of caring for a patient at the Home, we do know that the average is far below that at the General Hospital.

Table 6 shows the disposition and distribution of the patients in this group of fifty cases. Convalescent facilities were available through three sources; the hospital division of the Home for the Aged and Infirm, private convalescent homes, and the patient's own home. The two most significant factors to point out are: first, that the largest percentage of patients were referred to the hospital division of the Home for the Aged; and second, that the largest percentage of patients were fracture or orthopedic cases. These findings call for interpretation. Of the thirty-three patients admitted to the Home, twenty-five had lived alone prior to their admission to the General Hospital. The nursing care required during their convalescence could not be provided in their previous mode of living. The eight remaining patients had lived with their families, but due to the nursing care required,

crowded home conditions, and other health problems in the home, the family could not assume the responsibility for convalescent care. This group of thirty-three persons alone indicates the need for institutional convalescent facilities. Secondly, the diagnosis of the largest percentage of patients were fracture and orthopedic conditions. This group generally requires more extensive nursing care because of the treatment, with plaster cases, often immobilizes the person. The healing process usually extends from a period of several weeks to several months. Families are often able to care for these patients in their own home for a period of time, but their presence often necessitates economic and social readjustment. Few diagnoses require the same degree of occupational therapy, physiotherapy, and psycho-therapy that the orthopedic case does. These above mentioned therapies cannot be obtained at home. Therefore, for this group, institutional convalescent care is important.

It is not intended to overlook the importance of convalescent care to persons suffering with a cancer, for this group, more than any other, requires considerable medical attention, some of which can be secured through the out-patient clinic, but much of which calls for more frequent care than the patient is able to obtain by clinic

visits. On the other hand, we have those cases of cancer where either the family or the patient or both are aware of the diagnosis and know its meaning. In these instances, if conditions at home are such that the patient can be returned there for terminal care this plan is desired by the family.

TABLE 6

DISPOSITION AND DISTRIBUTION OF FIFTY SELECTED CASES DISCHARGED FROM THE SURGICAL WARDS AT THE LOUISVILLE GENERAL HOSPITAL FROM MARCH, 1941-MARCH, 1942

Disposition and Distribution of Patients	Total		Fractures		General Surgery		Cancer	
	No.	Per.	No.	Per.	No.	Per.	No.	Per.
Total	50							
Home for Aged and Infirm-Convalescent Ward	33	66%	23	70%	6	18%	4	12%
Private Convalescent Homes	7	14%	5	71%	2	29%	0	0
Patient's Own Homes	10	20%	6	60%	2	20%	2	20%

An interesting example of this is shown in abstract thirty-five,[1] the case of a fifty-six year old white woman whose malignancy appeared very suddenly. In spite of frequent hospital admissions and her knowledge that her life span was very limited, she would never consent to a separation from

[1] See Appendix II for abstract thirty-five.

her thirteen year old daughter, and her small, comfortable apartment. With the aid of a visiting nurse and the public relief agency she was able to adjust herself to her illness at home.

Abstract thirty-three[1] is the case of a twenty year old girl, the only child of elderly parents, with a diagnosis of metastatic disease of the bones, and pathological fracture of the right femur. After several admissions to private hospitals and finally to the General Hospital, the family was convinced of the hopelessness of the patient's condition. They requested that she be discharged as soon as hospital treatment was completed so that she might spend her last days at home. With the aid of a visiting nurse the patient was able to remain at home until she expired.

Table 7, which refers to the social status of the patient prior to admission to the General Hospital, is self-explanatory. The only observation to which attention is directed is the fact that persons living alone or homeless were dependent on institutional facilities for reasons which are obvious within themselves. Patients living with their families preferred to return to their families unless their diagnosis required more extensive care than the family was able to give.

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[1]See Appendix II for abstract thirty-three.

TABLE 7

SOCIAL STATUS OF FIFTY SELECTED CASES, PRIOR TO ADMISSION TO THE HOSPITAL

Social Status	Total	Convalescent Ward	Private Homes	Own Homes
Total	50	33	7	10
Lived Alone or Homeless	32	25	5	2
Lived with Family	18	8	2	8

Table 8, which shows the age distribution of the group, is likewise self-explanatory. However, it is worth noting that persons forty years of age and over tended to require care in either a public or private institution. On the other hand, patients between the ages of fourteen and thirty-nine were cared for either in private convalescent homes or in their own homes. This was possible because many of this group held accident insurance policies or had a member of the family who could care for them in a private home or in the patient's own home. It is important to also add here, from the author's observation, that the group below the age of forty years attached more stigma to convalescing in the Home for the Aged and preferred to work out an alternative plan acceptable to them.

TABLE 8

AGE DISTRIBUTION OF FIFTY SELECTED CASES

Age Groups	Totals	Convalescent Ward	Private Home	Own Home
Total	50	33	7	10
14-19 years	1	0	0	1
20-29 "	3	0	1	2
30-39 "	5	4	0	1
40-49 "	10	7	0	3
50-59 "	12	10	1	1
60-69 "	10	7	2	1
70-79 "	6	4	2	0
80 and over	3	1	1	1

Survey Of Twenty-Five Discharged Patients Selected At Random

This survey of twenty-five patients discharged on September 26th and 27th of 1942 is of particular significance to us since it involves persons who did not come to the attention of the social service department, and is also representative of the type of problems we might find in many discharges. As previously stated, our chief concern was whether patients were leaving the hospital following a surgical operation and returning to situations unsuitable for their period of convalescence.

Out of the twenty-five cases, it was found that six persons were living in homes where the environment was not conducive to speedy recovery to health. By poor environment conditions, we mean overcrowding, poor ventilation, uncleanliness, inadequate sanitary facilities, excessive stair climbing, no yards, and confusion from multiple housing units.

Outstanding among these was the case of Mrs. W., who had been a patient on the surgical ward for three months with a diagnosis of Lung Abscess. Although we had seen this patient frequently on the ward, she was discharged unexpectedly on Sunday when the social worker was not on duty. She left the hospital and went to the home of a sister who operated a rooming house on the third floor in a commercial district. The only place available for her was a small room about seven by ten, constructed of plaster board. It was ventilated by a trap door in the ceiling that opened into the hallway. The patient preferred to remain there until it could be determined whether the sister could arrange another room for her. The case was referred to the Visiting Nurse Association for daily care, and the Municipal Bureau of Social Service for financial assistance. Both agencies worked jointly with the medical social worker from the Hospital, thus enabling the patient to carry out the prescribed plan of treatment recommended by the Doctor.

A second case was that of a thirty-one year old

white woman with a diagnosis cancer. She was the mother of five children, all under sixteen years of age. The family occupied a four room cottage. In the absence of the father from the home, the full responsibility for the children fell to the patient. Although a visiting nurse was not needed in the home, the services of a housekeeping aid would have been helpful. Due to the curtailment of the Housekeeping Aid Project, there was no aid available. It is not possible to completely ascertain the influence this illness had on the young children, but we do know the anxiety which the patient was experiencing.

Of the twenty-five cases, four were the mothers in the home and had from three to five children under sixteen years of age to care for. In two instances the visiting nurse was giving service, but in none of these homes was there a housekeeping aid. Our survey also indicates that one of the mothers was the wage earner in the home and had returned to work out of necessity, even though her physical condition was such that she should have had a longer period of convalescence at home free from worry. Nine of the total number of patients were wage earners in the home but due to other resources, it was not necessary to apply for financial assistance from a relief agency.

It is felt from the survey that one of the most significant findings was the failure on the part of the

medical staff to discuss with the patient his diagnosis, his limitations, and the treatment he would be expected to follow. Of the twenty-five persons visited, ten left the hospital with no true knowledge of their diagnosis. They necessarily determined their own limitations.

In conclusion, it is felt with our knowledge of the minimum standards for convalescence, that of the twenty-five cases studied, ten patients could have profited by more adequate care either in their own homes, or in an institution or a nursing home.

Local Non-institutional Facilities For Convalescent Care

From our review of the convalescent ward at the Home for the Aged, it is obvious that this institution is not equipped to accommodate all persons discharged from the General Hospital who are in need of convalescent care. Even though there may be available bed space, it is the opinion of the medical and social agencies that many patients make a better adjustment and recovery from their illness in their own homes. This adjustment may be aided by community services such as the Visiting Nurse Association, Housekeeping Aid Project, the Out-Patient Clinic of the General Hospital, and public and private welfare agencies. During the last six months of 1941, there was an average of fifty-five Aids who served eighty-six families.

This was a valuable project to the health and welfare agencies and one on which they have depended to supplement their services.

Miss Alexander Matheson, Director of the Visiting Nurse Association of Louisville, made the following statement in regard to convalescent care in the patient's own home:

> The Visiting Nurse sees the need for convalescent care. A chance to recuperate after a surgical operation pays dividends. This is true under the best circumstances, but when the sick person comes from some of the homes the Visiting Nurse sees every day, this adequate care is vital to the sick person's return to health. This may mean an earlier return to an important defense job.[1]

The procedure of the social service department at the General Hospital is to refer to the Visiting Nurse association every patient who, to its knowledge, is in need of nursing care in the home. This decision should be made by the doctor who has seen the patient regularly on the ward.

The program of the public and private welfare agencies have expanded to include boarding home care, special diets, and transportation facilities to clinics. From the following statement made by Mr. Charles Rieger, Jr., Director of the Department of Public Welfare, we feel that that there is a recognition of the need for expanding

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[1]Statement made in August, 1942, by Miss Alexander Matheson, Director of the Visiting Nurse Association, as a contribution to this study.

facilities in the field of convalescent care.

> The provision of sufficient facilities for the care of convalescent persons is fundamental to the well-being of the community.
>
> Individuals close to this problem locally have indicated that present available facilities represent only a small percentage of the estimated need.
>
> Persons whose restoration to health is impeded because there are limited facilities to aid their recovery are likely subjects for long-time or permanent care by the community--with all of the attendant negative and costly factors involved.[1]

Since the Survey of Hospitals and Health Agencies of Louisville, made by Dr. Haven Emerson in 1924, there has been a recognition on the part of the medical profession, and the community, of the value of a program of convalescent care. In 1937, plans were drawn up for a Hospital for Chronic and Convalescent Patients and in 1939, another study was conducted by the Community Chest Organization.

Dr. Hugh R. Leavell, Director of Health, whose efforts have been directed to the health and welfare of the community at large, has made the following statement:

> Suitable convalescent care is not only important to patients but economical to the governmental body responsible for providing medical treatment. Proper after-care of illness tends to prevent relapses and hastens the time when a patient can return to his regular duties. Re-hospitalization is avoided; and the wage-earner has a shorter period with no income.
>
> General hospitals for the care of acute illness are usually not suitable for convalescent care. They have elaborate and expensive equipment, and more highly trained and specialized personnel than are

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[1]Statement made in August, 1942, by Mr. Charles Rieger, Director of Public Welfare, as a contribution to this study.

> required for caring for convalescents. Also an atmosphere more conducive to successful convalescence can be more readily produced in institutions specifically devoted to that purpose.
>
> Louisville, like most other cities, has been slow to make full provision for convalescent care. However, it seems certain that when broader social planning becomes possible, this important problem will require and receive consideration.[1]

In conclusion, convalescent care in its broadest sense is not a question of institutional provisions alone, for it involves practically all the professional and institutional services concerned with the treatment and re-establishment of the sick to normal living. It includes medical and dental practice, hospitals, dispensaries, visiting nursing care, medical social service, and family relief agencies. It means seeing the patient through to the fullest possible re-establishment in health. A question so wide in scope cannot be handled properly by anyone alone of the many groups concerned. Any adequate program must necessarily draw upon the collective experience and resources, of both public and voluntary agencies.

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[1]Statement made in December, 1942, by Dr. Hugh R. Leavell, Director of Health, as a contribution to this study.

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS AND RECOMMENDATIONS

In reviewing the field of Convalescent Care, the meaning of convalescence to the patient, and the available local facilities for patients having experienced a surgical operation, certain facts take on importance.

First, outside of the City of New York and other large communities, the movement for organized convalescent care is in its infancy. There has been a relatively recent intelligent interest in the program, but until institutional and non-institutional care is considered an essential part of the whole plan for the treatment of the sick, the health provisions in the United States are definitely lacking, both in quantity and variety.

Second, no medical history is complete until the story of convalescence is complete. A patient may have recovered from an illness and still be unprepared to assume routine duties. In considering adequate convalescent care, we must think in terms of the individual and of his nutritional, psychosomatic, and economic status. Convalescent care should be considered as a continuing service in which the patient, the hospital, the social worker, and the convalescent home all have a share. It is no

longer sufficient to send a person recovering from an illness or a surgical operation to the country where he will have good food, sunshine and a place to rest.

Third, the local facilities for the care of convalescents are inadequate. According to an agreement in 1934, between the Directors of Health and Welfare and the Superintendent of the Home for the Aged, twenty beds were allotted to the General Hospital for convalescing patients. There are, in reality, never that many available, thus, the patient remains in the General Hospital until a bed is available, or returns to his home where unfavorable home conditions sometimes are not conducive to recovery. The Home for the Aged could not hope to approach more than the minimum standards advanced by the Joint Committee on Hospital Care of the American Hospital Association,[1] and minimum standards for Convalescent Hospitals proposed by Dr. Corwin.[2] It is significant, however, that with an increased per capita allowance, the standards of the Home could be much improved.

The population of the Home is growing steadily and the admissions include an increased number in need of active

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[1] Institutional Care of Chronically Ill, (Chicago: American Public Welfare Association, 1940).

[2] Dr. E. H. L. Corwin, "Minimum Standards for Convalescent Hospitals," Hospitals, (December, 1940), pp. 23-27.

nursing and medical care. An enlargement of the hospital division could be arranged by utilizing space on the second and third floors of the Home. This factor has been brought to light for several years by the various superintendents of the Home and by the Director of Welfare in their recommendation that an increase in their budget be allowed for the installation of an elevator. This would make it possible to move semi-invalids from one floor to another.

No adequate allowance is made for special diets for individual patients though every effort is made with the present budget, to meet as nearly as possible, the needs of the patients. There is no dietitian on the administration staff, however, the services of the dietitians at the Louisville General Hospital are available. The Superintendent of the Home is a registered nurse. From a review of literature, this is considered good administration.

In addition to the Home for the Aged, which is a tax supported institution, there are in operation several small, privately operated and owned boarding homes which often serve as convalescent homes for patients who are able to pay for this care. A division of the Louisville and Jefferson County Board of Health exercises some supervision over these homes. However, in the absence of adequate local governmental control to support standards and supervision of these homes, they are not effective measures for con-

valescent care. Recently, a committee represented by the health and welfare agencies of Louisville, drew up recommendations for a city ordinance covering standards and supervisory control.

There is a division of opinion of the medical profession of the value of convalescence in the patient's own home. In general, Louisville has a well organized program of health and welfare service, which, if expanded, could in many instances, care for the convalescence of patients in their own homes.

The integration of the facilities for organized convalescent care, each with the other, and even more important, with hospitals and the medical profession, is an outstanding need. This necessary inter-relationship should not require the establishment of new agencies for cooperation and coordination. These exist in plenty, and with the growing recognition of the medical and social significance of convalescent care, it should be expected of the present medical, hospital, welfare, and financing agencies which maintain coordinating services on a community-wide basis, that they extend their services on a more generous scale to the convalescent homes and other similar facilities.

General Recommendations for A Program Of Convalescent Care

1. Improvement of professional services to provide a uniformly high standard of convalescent care in accordance with the advancing knowledge of medicine.
2. Development of medical social services as an essential implement of organized convalescent care.
3. A better integration of vacilities for convalescent care with hospitals, in order to provide continuity of medical care and to extend the benefit of a period of convalescence to all persons in need of such care.
4. Development of convalescent care facilities in relation to community needs so that, without unnecessary duplication, adequate facilities may be provided for the different medical, age, racial and economic groups in the population.
5. Extension of the hospital pre-payment plan to include pre-payment for convalescent care whenever such care is indicated by the medical and social needs of the patient.
6. Provision, where indicated, for convalescent care of persons coming under the Workmen's Compensation Act, such care to be paid for by

the employer or insurance carrier.

7. Reconsideration of the policies regulating governmental payments for the care of public charge patients in convalescent homes.
8. Development of joint fund-raising in cooperation with the existing financing federations.
9. Exploration of the possibility of establishing a central office for the admission of patients to convalescent homes.
10. Exploration of the possibility of establishing a centrally operated and maintained transportation service.
11. Consideration of the desirability of providing, on an organized basis, for periodic converences of representatives of the convalescent homes in order to permit an exchange of experience and equalization of standards.[1]

Specific Recommendations For Convalescent Care In Louisville, Kentucky

1. The appointment of a committee representing the Jefferson County medical society, all of the hospitals, and health and welfare agencies to conduct inquiry into the subject of convalescent

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[1] Jones, op. cit.

care and to form a community policy dealing with the various phases of the program.

2. To review and reconsider the recommendations made following the Community Chest Survey of 1939.
3. To utilize the already existing facilities for convalescent purposes and to modernize in every possible way, the Home for the Aged so that this institution may more than meet the very minimum standards.
4. To arrange for a segregation of the chronic and convalescent patients at the Home for the Aged.
5. To endeavor to secure an appropriation from public funds to finance a community program of convalescent care.
6. To establish an even closer working relationship between the social service department of the Louisville General Hospital and the medical staff so that all efforts may be directed toward a better understanding of each patient as an individual.
7. To establish some flexible system of part pay for those patients who are unable, financially, to meet the costs of care in a private convalescent home.

8. To encourage the establishment by city ordinance to force private convalescent homes to meet at least minimum standards of convalescent care.
9. To expand the program for non-institutional community resources, namely, the Visiting Nurse Association and replacement of the Works Progress Administration Housekeeping Aid Project.
10. To keep in mind the proposed hospital for chronic and convalescent patients, the plan of which has been placed in the post-war health program.

In conclusion, the movement to establish convalescent care as a recognized part of medical treatment should be carried forward systematically by organized groups in order to give the patient, in all forms of illness in which recovery is possible, the benefit of planned scientific care during convalescence, and to relieve the community of the burden of unnecessary hospital care and preventable disability.[1]

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[1] Jarrett, op. cit., p. 23.

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APPENDIX

APPENDIX I

Schedule 1.

Used in the study of fifty selected cases known to the Social Service Department of the Louisville General Hospital from March 1941 to March 1942.

Name . . . . . Age. . . . Color . . .

Diagnosis . . . . . .Marital Status. . . . .

Living with Family . . . . Separated from Family . . . . .

Living Alone Prior to Admission . . . . . .

Employed prior to Admission . . . . . .

Disposition at time of Discharge

A. Discharge to Own Home

B. Discharge to Private Convalescent Home

C. Discharge to Convalescent Ward, Home for Aged and Infirm

Date of Discharge . . . . . .Date of request for Transfer to Convalescent Ward . . . . . .

Date of Transfer to Convalescent Ward . . . . . .

Reason for going to Convalescent Ward . . . . . .

Schedule 2.

Used in survey of twenty-five cases discharged from surgical wards, September 26th and 27th, 1942.

Name . . . . . Age . . . Color . . .

Diagnosis . . . . . .

Number of Children over 16 years . . . . . .

Number of children under 16 years . . . . . .

Housing:

Apartment floor

Number of rooms

Number of units

Cottage

Patient in bed

All time

Part time

Not at all

Patient wage earner in home . . . Has he returned to work? . .

Is Patient the mother in the home? . . . . . .

Visiting housekeeper in the home . . . . . .

Visiting nurse giving service . . . . . .

Were diagnosis, treatment, limitations discussed? . . . . .

APPENDIX II

Abstract 32

Mrs. H., a 57 year old white woman, was admitted to the Surgical Ward with a Fracture of the Right Femur sustained in a fall in her bathroom. Steinman Pins were inserted in her hip and she required a convalescence involving no walking for a period of at least 4 months and possibly much longer. This patient had been a widow for 10 years. Following the death of her husband she had lived on a limited income from stocks and bonds until 3 years ago when it became necessary for her to secure employment through the Works Progress Administration. She was an adopted child of a very wealthy couple. Following the death of her father, her husband assumed the responsibility for handling her finances and during the depression he lost all of her inheritence through bank failures and bad investments. He died a mental case.

Her background included a college education, a year at a finishing school in New York and 3 years at the Conservatory of Music in Chicago. She taught for twelve years at the Conservatory of Music in this city and when she was employed by WPA she was placed on Music Project.

This patient had been accustomed to very comfortable living conditions, but due to misfortune in recent years she had been forced to be dependent upon society. Only through the interpretation of the facilities which were available for convalescence and with the encouragement of very good friends did this patient agree to go to the Convalescent Ward for this period of recovery.

Abstract 33

Marion, a 26 year old white girl, was admitted to the Surgical Ward with a diagnosis of Metatastic Disease of the Bone and Pathological Fracture of the Right Femur. She was placed in a Right Hip Spica Case which immobilized her. This patient had been in private hospitals on six different occasions in the past six months to receive Deep Xray Therapy for a Malignancy. The family had exhausted all savings and insurance policies in an effort to provide medical care for her outside a public institution. It finally became necessary for them to arrange for her transfer to the Louisville General Hospital.

This patient was an only child of an elderly couple. She graduated from high school at the age of 16 and completed one year of training in a local business college. She had worked for the past 9 years prior to her illness in a local insurance company and had assisted in the support of her parents. She was well educated through her extensive reading and her social contacts, and was not informed of the nature of her illness.

This was a well integrated family group interested in the patient's welfare and eager to have her in the home during the terminal stages of her illness. They felt that with the assistance of a visiting nurse and the hospital for her medical treatment she could be adequately cared for in her own home.

The patient was visited regularly for the purpose of a friendly contact and for interpretation to the family of Marion's condition during the various stages.

Abstract 35

Mrs. W., a 56 year old white woman, was admitted to the Surgical Ward with a diagnosis of Cancer of the Cervix. During the period when she was a patient on the ward she received Deep Xray Therapy and at the time of her discharge was advised to return daily to the Out-Patient Clinic for the continuation of these treatment. She was unable to continue to make these trips to the hospital and finally discontinued her treatments.

Three years ago this patient's husband deserted the family and returned to England, his home. Mrs. W. attempted to support her two children, ages six and ten, through a small delicatessen, but the business was not remunerative and it became necessary for her to dispose of it. A few months prior to her illness she had been living on the money which she secured from this sale and still had enough to carry her for approximately a month. Her brother in New York City had taken the youngest child to care for and she continued to keep her daughter, now 13 with her. The daughter was presenting numberous problems which were a source of worry to the patient. Although this child was not old enough to accept the responsibility required of her during her mother's illness, she was of some value in the home.

An arrangement was made to secure financial assistance for this patient through a public relief agency that urged her to go to a private nursing home financed by them and to place her daughter in a foster home. She, however, refused to surrender her independence and her responsibility for the child. The relief agency agreed to continue to assist the family and with the aid of a visiting housekeeper provided through the WPA program, and a Visiting Nurse, the patient made a fair adjustment in her home.

APPENDIX III

Minimum Standards for Convalescent Homes[1]

A convalescent institution is not a vacation home or a custodial home or a chronic disease hospital. It is a medical institution designed for patients recovering from acute illnesses, operations and exacerbations of illnesses which may be chronic in their nature.

A convalescent institution should have an adequate physical plant; proper location, either in a suburban area or within the city limits; and proper equipment for the comfort and scientific care of the patients, for recreation, and for other adjunct therapeutic procedures necessary to bring the patient back to his normal mode of health and life.

The rules and regulations governing the management of the convalescent hospital should be worked out in cooperation with the medical authorities of the institution. The admission policy and other social policies of the institution should be developed in conference with the representatives of the social and medical agencies of the community.

Each convalescent hospital should have an experienced administrative officer, as well as a resident medical officer whose selection should be based not only on his medical train-

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[1] Dr. E. H. L. Corwin, "Minimum Standards for Convalescent Hospitals," Hospitals, (December, 1940), pp. 23-27.

ing but on his understanding of the psychic and emotional problems of convalescent patients and his interest in the patient as a human being. Each institution should employ a dietitian to be responsible for the basic diet which should be adequate in all essential elements, and to provide for the types of special dietaries recommended for various nutritive deficiencies. Each institutuion should have at least one qualified registered nurse for every so many patients. Small institutions serving a particular community should either merge or provide essential services in some cooperative way.

Each institution should have an advisory medical board composed of representatives of the medical staffs of hospitals sending patients to the institution. This board should be responsible for the medical policies and procedures of the institution and should supervise the work of the resident physician.

While it is unnecessary for the convalescent institution to duplicate the services which are provided by the social service department of the hospital, some cooperatiem arrangement should be made whereby the convalescent home might inform the hospital social service department of personal and environmental conditions that have been discovered during the patient's stay in the home. There is need of an educational follow-up policy on the part of the social

service departments of the hospitals whereby the patients and their relatives would be instructed in their own homes as to the best care which can be provided with the facilities at hand.

The rules of admission to all institutions should be so ordered as to preclude the necessity for a hiatus between the hospital and the convalescent home. There should be synchronization of the patient's discharge from the hospital with his admission to a convalescent home.

All policies which tend to fix the duration of convalescent stay should be abandoned in favor of more flexible rules which permit the variation of this period to accord with the time necessary for complete or optimum restoration.

Special institutions for the care of certain types of convalescents should be encouraged, particularly for cardiac patients, orthopedic patients, and patients convalescing from disturbances which are frequently accompanied by temporary psychic imbalance, and for those neurological patients for whom there is reasonable assurance of improvement.

In the case of orthopedic patients the concept of convalescence should extend beyond the patient's stay in a convalescent home. A physical handicap may make it necessary for the patient to find a new outlet for his economic usefulness. A complete orthopedic convalescent program should, therefore, include training to fit the patient into

a new occupational pattern. Vocational training is hardly possible in a convalescent institution unless it be of a specialized type.

Either an official agency or a self-appointed body should review annually the work of the various institutions for the purpose of pointing out the ways and means of bolstering up the standards of performance, review the current progress in this field work, and stimulate improvements as well as scientific research.

APPENDIX IV

Proposed Chronic and Convalescent Hospital

The plans for this building call for a basement and three floors with white and negro patients occupying separate wings on each floor. Identical facilities are provided for each group on every floor.

The basement is designed to house the following:

Occupational therapy departments
Kitchens
Cafeterias
Dietitian's offices
Bakeries
Canteens
Chapels
Mortuaries
Elevators

First Floor:

4 twelve bed wards
4 ten bed wards
6 private rooms
4 day rooms
3 solari
1 service pantry
1 visitor's room

1 reception room

1 receiving room

1 central record room

1 Superintendent of Nurses office

Operating room

Doctor's office

Building Superintendent

Auditorium

Main office and lobby

Second floor:

4 twelve bed wards

4 ten bed wards

10 private rooms

Third floor:

1 ten bed ward

7 private rooms

1 treatment room

1 isolation room

Lobby

Lounge

Utility room

The physical structure presents an attractive three story brick building so designed that it can be easily enlarged.